Mission Sector

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Faith groups play a significant role in providing health care around the world. Their motivation is concern for the healing and wholeness of the human person. The Mission sector is a term used to define the contribution of all faith based health care providers. However this discussion of the involvement of the mission sector in health care and medicine supply concentrates on church based health services.

In Africa, the involvement of missionary organizations in health care goes back over a hundred years. Indeed many of the first hospitals established were church based with the colonial administrations joining in to provide health services only much later.

Most mission sector health providers describe themselves as existing to serve the poor, marginalized and unreached (CHAL, 2008; CHAM, 2007; CHAG, 2008) and as such the activities of these churches tend to be more concentrated and more significant in rural areas. For a country like Malawi over 70% of the health care in the rural areas is provided by facilities belonging to the churches. However even in Sub Saharan Africa wide variations exist in the involvement of the church in health care delivery and medicines distribution. For countries like South Africa, church based health care is virtually non existent (Coovadia et al., 2009; Patel et al., 2009). Less often spoken about is the church active in health care delivery outside Africa. In Papua New Guinea (PNG) for example, the churches provide up to 50% the country's health services and are well integrated within the national health system (AusAid, 2009).

Any health system is expected to deliver appropriate health products and services in an equitable, reliable and efficient manner (Ballou-Aares et al., 2008; AusAid, 2009). From a public perception, one of the key measures of the effectiveness of the system is its ability to provide medicines. The fact that church health services in Africa have continued to survive in spite of decades of challenges (Konde-Lule et al., 1996) could be a testament to the fact that the quality of services offered including the provision of medicines meets the needs of the populations targeted.

Faith based organizations in three African countries were, in the late nineties, estimated to handle between 20% and 40% of their country's pharmaceuticals (Kawasaki & Patten, 2002) however not much data is available on the exact contribution of the different church based players to medicine supply in Africa. Banda et al. (2006) undertook on behalf of the World Health Organisation (WHO) and the Ecumenical Pharmaceutical Network (EPN) the most comprehensive study to-date on the work of the churches involved in medicine supply. This essay draws a lot from this work.

The church run pharmaceutical supply systems vary greatly in size, nature of operation and impact within the country in which they are situated. In some countries the systems are

well developed with one agency undertaking procurement, warehousing and distribution for the entire sector. In these cases the central units such as MEDS in Kenya, CHANMedi-Pharm in Nigeria and Joint Medical Store in Uganda are significant players supplying pharmaceuticals to their national markets and beyond (MEDS, 2008; Kawasaki & Patten, 2001). These organizations also offer value added services such as the quality testing of medicines and training on rational medicine use (MEDS, 2008). Others such as Catholic Drug Centre which is the pharmaceutical supply arm of the Christian Health Association of Ghana have had mixed fortunes and are currently not operating to their full capacity (Ballou-Aares et al., 2008). Among the success factors identified for the church run supply systems are transparent procurement procedures, motivated staff (even when these staff are seconded from government health sector) and competitive pricing (Banda et al, 2006). Outside Africa, the Comprehensive Medical Services India (CMSI) is an example of a church initiative also aimed at providing high quality affordable essential medicines. Owned by Inter Church Services Association (ICSA) a national ecumenical body, CMSI is involved in medicines manufacture and distribution as well as training on rational use of medicines (ICSA, 2009). In general the mission sector supply system rarely operates as a distinct entity. More often than not it is interconnected with the other supply systems in the country including public and private for profit (Ensor & Witter, 2001 in Bennett et al., 2005; Ballou-Aares et al., 2008; CHAK, 2008)

Current issues

The discussion on the state of the mission sector focuses on two key areas, namely (a) medicines availability and quality, and (b) financing.

Availability and Quality of medicines

The church systems appear, in general, to be comparable to or slightly better than the public sector as far as medicines availability is concerned. This is particularly so in countries where the pharmaceutical supply system includes a central or regional procurement and / or distribution unit. In Uganda, a recent survey showed that the availability of key essential medicines in mission health facilities was 57%, higher than both the public and the private sector (MoH Uganda, 2008a). However the situation is still very far from ideal and church health facilities across the region, for various reasons, are not able to guarantee continuous availability of medicines (Banda et al., 2006; CHAM, 2007; CHAL, 2008).

Historically church pharmaceutical systems have depended on internationally reputable suppliers such as ECHO International Health which led the way in establishing low cost supply services to developing countries, and others such as the International Dispensary Association and Action Medeor (Banda et al., 2006; DIFD, 2001; Kawasaki & Patten, 2002). Competition from the private sector and a dwindling resource envelope has forced the drug supply organizations and the church health facilities to diversify their sources in order to remain attractive to their clients. Currently the lowest priced medicines are largely from China or India or, in a few cases, from local manufacturers in countries. These developments alongside weak regulatory systems in many countries make the mission

sector vulnerable to sub standard medicines. The situation is further compounded by the fact that most of the church based distribution systems lack comprehensive quality assurance systems (Banda et al, 2006).

Perhaps surprisingly Mission for Essential Drugs and Supplies (MEDS), a church based pharmaceutical organization that carries out routine testing of medicines, registered a less than 5 % failure rate every year of the samples (1565) randomly tested from its own stocks over a five year period, 2004 – 2008 (MEDS, 2008). The failure rates from samples from external sources were significantly higher with an average of 8.9% failure rate per year recorded from the 1041 samples tested over the period (MEDS, 2008). On the other hand Joint Medical Store, a church based drug supply organization in Uganda, reported an 11.6% failure rate for samples tested over a 12 month period in 2008-09 (JMS, 2009). The fact that both these organizations have a number of other quality assurance mechanisms in place to guarantee the quality of their own stocks and their reputation as quality conscious providers may explain why the results appear lower than one might have expected.

Financing

Financing is an area of particular difficulty for church health service providers. In the past church systems depended heavily on donations of medicines from partners in Europe and America. Greater regulation of importation, increased international awareness about the need to control donations and shrinking churches in the west have all contributed to significantly bringing down the donations of medicine in kind. Currently support to the efforts of the mission sector to provide medicines comes from many sources both secular and religious. However the sector still relies heavily on the ability of those seeking care to pay for the medicines regardless that the capacity of the average citizen to pay for the medicines they need is still quite low (MoH Uganda, 2008b). This poses a dilemma for Church health facilities. On the one hand, the sell of medicines provides the easiest source of regular income. Monitoring of expenditure on and revenue from medicines is relatively easy and the revenue from the medicines can be used to offset other health care delivery costs. On the other hand, it is a very visible cost to the patient and a clear barrier to access. As such church facilities are continually struggling to find the right balance for medicine pricing in particular and of services in general to be able to survive while fulfilling their calling to serve the poor.

Challenges

Recognition of the contribution of private not profit health providers is an issue which tends to be highly political. Some policy makers choose to ignore the contribution of church health systems altogether (Bennett et al., 2005). As a result of the largely informal engagement with government and major funders of health, the potential of the missions to support increased access to medicines has not been fully exploited. Governments being the more dominant players in all cases and having the ultimate responsibility for the health of the citizens need to do more to ensure that the efforts of all non-state actors are supported. The churches on their part need to properly document and broadcast their contributions to health service delivery while ensuring that their services are in line with the national

strategies and plans. Nonetheless some governments have established win win relationships with churches in health as in Zambia (EPN, 2010). These successful models could be replicated in other countries.

The contribution of global health initiatives to significantly increased access to medicines by the poor in developing countries goes without question. However their impact on local and national medicine supply systems in general and those of the church in particular needs to be studied. It appears that not enough attention is being paid to the possible adverse effects that these initiatives could have on existing systems in poor countries. Possibly blue prints on how these agencies should engage with the church sector and other private not for profit sector players could be developed so that efforts to solve one issue do not contribute to an even worse situation in the long term.

It has been argued running of national systems for health care and the supply of medicines in developing countries should be left to governments since it is the role of the state to provide health care and as such medicines for its citizens. Ironically more and more mission health care providers whose services continue to be required, feel that the only way to guarantee supply of affordable medicines within their facilities is if have their own supply organizations independent of either the private for profit or the public sector. In countries such as Ethiopia and Chad church health service providers under their umbrella bodies are proactively looking for the means to set up medicines supply organisations (EPN, 2009). As long as there is a need the Church in keeping with its faith will seek to respond.

Way Forward

Good relationships with and support from governments and other key health sector players are crucial to the survival of the church health systems. Nonetheless the possibility of full integration of the church health facilities and medicine supply systems into the public sector in Africa and elsewhere seems unlikely in the near future. Many church facilities would like to retain their identity and philosophy of care which may not be possible if they are completely under another authority. However without the commitment of governments to supporting the mission sector, ultimately it will be the ordinary person who will continue to suffer. Collaboration then seems like an obvious win-win for church health services and governments grappling with continuing inadequacy of resources while facing greater demand for a reasonable standard of health care for their citizens.

The fact that church based health service providers tend to be organised under umbrella organizations provides a huge opportunity to facilitate and implement better engagement with governments as well as other bodies that may wish to support the sector. The numerous barriers and prejudices that exist can be overcome, and real and meaningful partnerships which guarantee equity of access to medicines for all citizens, established.

Further Reading

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